

Authorization for Release of Information

Section 1: Information About the Use or Disclosure

I authorize the use or disclosure of personal health information about me or my dependent child(ren)* as described below. I understand that this authorization is voluntary and I may cancel it at any time as described in Section 2.

Name			
	First name	Last name	Middle initial
I am enrolled in	☐ Basic Health	☐ Public Employees Benefits Board (PEBB)	My I.D. number
A 4 la 4 i .			
Authorization			
me or	my dependent child	(person or organization)	tion) to provide information about
		n) to provide information on*	
	he Health Care Aut	• •	ependent child(ren)* to
Name(s) of	dependent child(rer	n) to provide information on*	
Specific informa	ion to be used or di	sclosed (including dates if needed)	
Reason for discl	osure/purpose of dis	sclosure	
This authorization	n will expire on		
		Date or event relating to you or the purpose of	of this form
*\A/han atata law	allows parent or au	ardian to ralagge information	
vviieri state iaw	allows parent or gu	ardian to release information.	
Section 2: I	mportant Infor	mation About Your Rights wing statements about my rights:	
Section 2: In I have read and	mportant Informunderstand the folloon	mation About Your Rights wing statements about my rights: any time prior to the expiration date or event noted a	above by telling the Health Care Authority in writing. Th Authority before the cancellation notice was received.
Section 2: In I have read and I may cancel to cancellation w	mportant Informunderstand the folloon his authorization at ill not affect any info	mation About Your Rights wing statements about my rights: any time prior to the expiration date or event noted a	above by telling the Health Care Authority in writing. Th Authority before the cancellation notice was received.
Section 2: II I have read and I may cancel to cancellation w I may see and I am not required Health Care A	mportant Inforum understand the following authorization at fill not affect any information copy the information at the sign this form uthority may not religious under the sign that the	mation About Your Rights wing statements about my rights: any time prior to the expiration date or event noted a bright about my rights: any time prior to the expiration date or event noted a bright about 1 and	Authority before the cancellation notice was received. treatment, or payment. If I do not sign this form, the
Section 2: II I have read and I may cancel to cancellation w I may see and I am not requing Health Care Acoverage, eligo The person or organization. I dependent ch	mportant Inforunderstand the following authorization at ill not affect any information at copy the information at the sign this formuthority may not relibility, and enrollment organization that I a have the right to as Id(ren)* with anyone	mation About Your Rights wing statements about my rights: any time prior to the expiration date or event noted a branation either received or given by the Health Care and described on this form if I ask for it. to receive health care benefits, such as enrollment, ease my information to any person or organization e nt, or as allowed by law.	Authority before the cancellation notice was received. treatment, or payment. If I do not sign this form, the xcept those needed to determine my continued endent child(ren)* might share it with another person of yees do not share information about me or my without my further authorization. Exceptions may
Section 2: II I have read and I may cancel to cancellation w I may see and I am not required Health Care Acoverage, eligo The person or organization, dependent chinclude person	mportant Inforunderstand the following authorization at ill not affect any information at the following and the formation at the formation at the following and the following	mation About Your Rights wing statements about my rights: any time prior to the expiration date or event noted a primation either received or given by the Health Care and described on this form if I ask for it. to receive health care benefits, such as enrollment, ease my information to any person or organization e nt, or as allowed by law. authorize to receive information about me or my dep to the Health Care Authority to ensure that its employed other than the person or organization noted above	Authority before the cancellation notice was received. treatment, or payment. If I do not sign this form, the xcept those needed to determine my continued endent child(ren)* might share it with another person o yees do not share information about me or my without my further authorization. Exceptions may ity, and enrollment, or as allowed by law.
Section 2: II I have read and I may cancel to cancellation w I may see and I am not required Health Care Acoverage, eligo The person or organization, dependent chinclude person	mportant Information at the following authorization at the following authorization at the fill not affect any information at the fill not affect any information at the fill a	mation About Your Rights wing statements about my rights: any time prior to the expiration date or event noted a branching either received or given by the Health Care and described on this form if I ask for it. to receive health care benefits, such as enrollment, ease my information to any person or organization e nt, or as allowed by law. authorize to receive information about me or my dep ek the Health Care Authority to ensure that its employ e other than the person or organization noted above needed to determine my continued coverage, eligibil	Authority before the cancellation notice was received. treatment, or payment. If I do not sign this form, the xcept those needed to determine my continued endent child(ren)* might share it with another person o yees do not share information about me or my without my further authorization. Exceptions may ity, and enrollment, or as allowed by law.
Section 2: II I have read and I have read and I may cancel to cancellation we I may see and I am not requited Health Care Acoverage, elige The person or organization, dependent chinclude person The Health Care Section 3:	mportant Informunderstand the following authorization at ill not affect any information at the following and the formulation or the formulation or the following and the follo	mation About Your Rights wing statements about my rights: any time prior to the expiration date or event noted a primation either received or given by the Health Care and described on this form if I ask for it. It or receive health care benefits, such as enrollment, ease my information to any person or organization e ant, or as allowed by law. In authorize to receive information about me or my dep six the Health Care Authority to ensure that its employ the other than the person or organization noted above needed to determine my continued coverage, eligibil to Notice is available upon request by calling 360-92	Authority before the cancellation notice was received. treatment, or payment. If I do not sign this form, the xcept those needed to determine my continued endent child(ren)* might share it with another person of yees do not share information about me or my without my further authorization. Exceptions may ity, and enrollment, or as allowed by law. 23-2822 or online at www.hca.wa.gov.
Section 2: II I have read and I have read and I may cancel to cancellation we I may see and I am not required Health Care Acoverage, elige The person or organization, dependent chinclude person The Health Care Section 3: S Signature of enro	mportant Information at the following authorization at the following authorization at the fill not affect any information at the fill not affect any information at the fill a	mation About Your Rights wing statements about my rights: any time prior to the expiration date or event noted a primation either received or given by the Health Care and described on this form if I ask for it. It or receive health care benefits, such as enrollment, ease my information to any person or organization e nt, or as allowed by law. In authorize to receive information about me or my dep six the Health Care Authority to ensure that its employ the other than the person or organization noted above the edded to determine my continued coverage, eligibility The Notice is available upon request by calling 360-92 The Secondary of the Care Authority to the coverage of the cove	Authority before the cancellation notice was received. treatment, or payment. If I do not sign this form, the xcept those needed to determine my continued endent child(ren)* might share it with another person o yees do not share information about me or my without my further authorization. Exceptions may ity, and enrollment, or as allowed by law.

or fax to 360-923-2608

If PEBB member—Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684